

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 111 WEST CHURCH AVE SEYMOUR, IN47274			
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F0000	<p>This visit was for the Investigation of Complaint IN00092272.</p> <p>Complaint IN00092272- Substantiated, Federal deficiencies related to the allegations are cited at F323.</p> <p>Survey date: July 14, 2011</p> <p>Facility number: 000347 Provider number: 155715 AIM number: 100275440</p> <p>Survey team: Marla Potts, RN, TC Melinda Lewis, RN</p> <p>Census bed type: SNF/NF: 106 Residential: 29 Total: 135</p> <p>Census payor type: Medicare: 13 Medicaid: 56 Other: 66 Total: 135</p> <p>Sample: 4</p>			F0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F0323 SS=G	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 18, 2011 by Bev Faulkner, RN</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were provided with interventions and supervision resulting in repeat falls for 2 of 4 residents reviewed for accidents in the sample of 4. Both residents sustained hip fractures. Resident B and Resident D.</p> <p>Findings include:</p> <p>1. Resident B was identified as having had a recent fall and fracture by the Health Facility Administrator on 7/14/11</p>			F0323	<p>F323 Free of Accident HazardsIt is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.I. Corrective Action For Residents Affected:Resident B - The fall risk assessment of the resident was reviewed. The care plan was reviewed and the appropriate interventions are in place including alarms to alert the staff to any attempt to transfer alone. The resident received therapy following the hip repair</p>		08/08/2011

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	<p>at 10:00 A.M. Resident B was observed on 7/14/11 at 11:00 A.M. to have been in his room, sitting in a recliner with an alarm to alert staff of unassisted transfers. Resident B's room was observed at the end of a hallway, in one of the rooms farthest from the nurses' station.</p> <p>Resident B's clinical record was reviewed on 7/14/11 at 10:30 A.M. The record indicated the resident was admitted to the facility in March of 2011. He was placed on the rehab unit of the facility to receive therapy services. The transfer record, dated 3/11, indicated the resident had a history of falls. The admission Minimum Data Set assessment, dated 4/4/11, indicated the resident had no cognitive loss at that time.</p> <p>A care plan problem, dated 3/29/11, of "resident at high risk of falls related to history of CVA (cerebral vascular accident), weakness and unsteady gait." Interventions included: "proper foot wear, call light in reach, side rails to assist with transfers and bed mobility, therapy, transfer and ambulate with 2 assist, gait belt and quad cane, 5/9/11 toilet resident on return to unit after mealtime, 6/12/11 offer to transfer resident to recliner after mealtime."</p> <p>Physical therapy notes, dated 5/24/11,</p>				<p>surgery to increase his strength, endurance, and activity tolerance, and also to educate staff, resident, and family on safe transfers. Staff education was completed on his care. Resident D - The fall risk assessment of the resident was reviewed. The care plan was reviewed and the appropriate interventions are in place including alarms to alert the staff to any attempt to transfer alone. The resident received therapy following the hip repair surgery to increase her strength, endurance, and activity tolerance, and also to educate the staff, resident, and family on safe transfers. Staff education was completed on her care. II. Other Residents Having The Potential To Be Affected: All residents who are at high fall risk have the potential to be affected. The falls policy and procedure was reviewed and evaluated based on current evidence based practice. (Attachment titled Fall Management). The falls policy and procedure includes assessment, planning, intervention, and evaluation to complete the nursing process. The Post Fall Reporting form is used after the fall and guides the investigation of the fall, prompts physician notification, and also interventions to prevent another fall. (Attachments titled Post Fall Reporting Form). The Fall Management Policy and the Post Fall Reporting Form were</p>		

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	<p>indicated "Patient requires supervision to safely ambulate 150 feet," requires stand by assist for transfers," requires supervision to safely complete full functional transfers."</p> <p>The falls risk assessments indicated the following: 5/6/11- 9:24 p.m., resident alert and oriented with 1 to 2 falls in past 3 months 5/8/11- 8:57 p.m., resident having intermittent confusion 5/24/11- 6:31 p.m., alert and oriented, with 1 to 2 falls in past 3 months 6/12/11- 7:29 p.m., intermittent confusion 6/24/11- 11:36 p.m. intermittent confusion</p> <p>Nurse notes indicated:</p> <p>A post fall reporting form, dated 5/8/11, at 5:40 p.m., indicated Resident B had a fall in his bathroom, due to weakness, getting up from the wheelchair on his own, "resident stated that he thought he could toilet himself, transferred self from wheelchair and fell to floor, landed on bottom with legs extended out." Cause-other-Resident brought back from C wing supper and left on this side of double doors (D wing) Res propelled self to room to self toilet." Physical status-weakness, recent acute illness cerebral vascular accident with left hemiplegia. Summary- Res brought back</p>				<p>updated to include an automatic therapy referral for evaluation of the resident to see if therapy intervention would be beneficial to improve strength and balance to help prevent future falls. The Fall Management Policy and the Post Fall Reporting Form were also updated to prompt a Pharmacy Notification for review of medications to determine if medication side effects potentially contributed to the fall and if pharmacy recommendations need to be made to the physician.III. Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur:In addition to the changes listed above that are in place after the fall occurs, changes were made to shift the facility's focus to a more proactive approach to prevent falls from occurring. Mandatory education was held with the nursing staff on July 25th and July 27th and August 3rd, 2011. (Attachment titled Mandatory Education). Included in the staff education was a review of the fall management policy, the definition of a fall, a review of intrinsic and extrinsic risk factors to assess, how to do a thorough fall risk assessment, interventions for intrinsic and extrinsic risk factors, and shifting our focus from crisis management when a fall occurs to a proactive reduction of fall risk and related injuries. Education</p>		

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	<p>to D-wing from C-wing after supper. D wing staff not aware res returned to wing, suppertime going on. Res propelled self back to room in wheelchair and tried to self toilet. First fall, care plan updated, intervention added to high fall risk intervention alert sheet-yes.</p> <p>The fall follow- up interventions included: 15 minute checks, C wing staff to notify D wing staff when resident returns to D wing, ask spouse to encourage resident to use call light, seat in lounge after meals, toilet after each meal.</p> <p>5/9/11- 10 p.m. " direct care staff reviewed fall of 5/8/11. Resident usually needs to toilet after meals...will discontinue 15 minute checks and keeping resident in lounge area after meals. Sitting in lounge on (name of unit) would not be appropriate for resident, it would upset him."</p> <p>5/24/11- 6:30 p.m. "resident transferred self from his wheelchair to recliner in lounge area per self. Didn't ask for staff assist...."</p> <p>5/26/11- "6 p res transferred self from his wheelchair to toilet in room... per self. No staff assistance. Res was previously in lounge area for few minutes. Res stating wanting to call police because someone</p>				<p>was also completed that we will begin high fall risk meetings weekly that will be held on the nursing unit to review all residents at fall risk and discuss their care and needed changes and update their plan of care. An audit tool was developed that will be used by the Director of Nursing or her designee to ensure that these meetings are occurring and that when additional interventions are needed that they are added to the resident's care plan and profile. (Attachment titled Residents At High Fall Risk). An audit tool was also developed that will be used by the Director of Nursing or her designee to evaluate and monitor staff's adherence to the fall management policy and to ensure that the proper care of the resident occurs. (Attachment titled Fall Audit Tool). Nursing staff were also educated on the proper process to transfer a resident from one unit to another and the importance of sharing the resident's routines with the receiving unit as well as the importance of sharing in detail all of the safety measures in place to prevent falls. A transfer form was developed and staff members were educated on its use. (Attachment titled Internal Wing Transfer of a Resident). The transferring unit will also plan a meeting with the receiving unit to discuss the resident's care and for there to be an opportunity to ask and answer questions to</p>		

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	<p>stole his van stated this times 2...6:15 p.m. ...Dr notified of increased confusion...no new orders just observe..."</p> <p>"6/3/11- 1:15 p.m., transferred to room (number on A unit, off D unit where he was)"</p> <p>The next nurses note entry was 6/12/11 6:30 p.m. and included a new order for x-ray of left hip.</p> <p>A post fall reporting form, included as part of the nurses notes, dated 6/12/11 at 5:45 P.M., indicated the resident had a fall, in his room, probable cause-lost his balance, was transferring self from wheelchair to recliner, complaint of left hip pain, history of falls on 5/8/11. Summary-Res in room in wheelchair attempted to transfer self to recliner without using call light to ask for any assistance, history of falls and stroke, new intervention-offer to transfer to recliner after mealtime.</p> <p>Nurses notes indicated he was sent to the hospital the next day, 6/13/11, with a diagnosis of fractured hip.</p> <p>The MDS assessment, dated 6/13/11, a discharge assessment, indicated the resident had an acute mental status change, had a short term memory</p>				<p>improve this hand off of care. The primary nurse and primary certified nursing assistant from the transferring and receiving units will be involved in this meeting. Documentation of the transfer, report and this meeting will be made in the nurse notes. Each transfer of residents between units will be audited to ensure that the form was completed, that report was given and documented, and that the meeting between staff occurred and was documented. An audit tool was developed to document the findings that will be used by the Director of Nursing or her designee. (Attachment titled Internal Transfer Audit Tool).IV. Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. IF the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop. The results of audits will be reviewed by the Quality Assurance Committee monthly.</p>		

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	<p>problem, and required assistance to make decision.</p> <p>During interview on 7/14/11 at 11:30 A.M., with the Director of Nursing, she indicated she felt the room change may have contributed to his increased confusion. She indicated he became more confused during the facility stay.</p> <p>The facility lacked evidence of having implemented increased supervision or alternate interventions when the resident started showing signs of increased confusion and attempting self transfers.</p> <p>2. The clinical record for Resident D was reviewed on 7/14/11 at 10:30 A.M. The record indicated Resident D had diagnoses that included but were not limited to Alzheimer's Disease. The Admission MDS [Minimum Data Set] assessment, dated 5/30/11, indicated Resident D was unable to complete the interview for mental status. The staff assessment for mental status indicated Resident D had short and long term memory problems and severely impaired decision making. Resident D required extensive assistance of two with bed mobility, transfers and toilet use. Resident D required limited assistance of two with ambulation. The MDS indicated Resident</p>						

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	<p>D had fallen two or more times without injury since admission.</p> <p>The Resident Admission Assessment, dated 5/23/11 at 2:00 P.M., indicated "...Family stated gets up unassisted at night..."</p> <p>A Care plan, dated 5/23/11, indicated "Resident at high risk for falls R/T [related to] dementia, weakness and unsteady gait. Res [resident] very HOH [hard of hearing]." The interventions were "1. Call light within reach. 2. Side rails to assist with transfers and bed mobility. 3. Therapy per MD orders. 4. Transfer and ambulate with 1 assist and use of gait belt. 5. Non-skid foot wear with transfers and ambulation. Clip alarm in bed and chair. Floor mat sensor beside bed. 5/25/11- 15 minute checks. 5/25/11- When room available, move closer to nurses station. 5/25/11 wear gripper socks while in bed." The clinical record lacked any documentation of Resident D being moved closer to the nurses' station.</p> <p>The fall care plan, dated 5/23/11, was updated on 6/14/11 to include the intervention of "Use gait belt until res in bed."</p> <p>The fall care plan, dated 5/23/11, was updated on 6/15/11 to include the</p>						

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	<p>intervention of "Assist res to bed btwn [between] 8p-9p if will allow."</p> <p>The Nurses Notes, dated 5/25/11 at 4:45 A.M., indicated "Fall at 4:30 AM was on end of recliner and sat on foot rest chair went to floor and res slid out to floor. No injuries noted..."</p> <p>The Nurses Notes, dated 5/25/11 at 11:15 P.M., indicated "Res found sitting on floor at 7 AM...."</p> <p>The Post Fall Reporting Form, dated 5/25/11 at 7:00 A.M., indicated "...Restless. Trying to get out of bed. might have gotten legs tangled in catheter tubing. Catheter pulled out when staff walked in..."</p> <p>The Post Fall Reporting Form, dated 6/14/11 at 10:00 P.M., indicated "...Fall to floor...reach out for bed. leaned over too far and fell out of wheelchair...no injuries at this point..." The Post Fall Reporting Form indicated it was a witnessed fall. The form lacked any documentation of who had witnessed the fall or if anyone was assisting Resident D at the time of the fall. The Nurses Notes lacked any documentation of the fall on 6/14/11.</p> <p>The Nurses Notes, dated 6/15/11 at 6:50 P.M., indicated "Met with direct care staff</p>						

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	<p>c/o [complaint of] (sic) fall of 6-14-11. Staff to use gait belt on resident until in bed to allow greater control for res safety. Staff to also attempt to assist res to bed btwn [between] 8P-9p before she gets too tired."</p> <p>The Nurses Notes, dated 6/17/11 at 9:00 A.M., indicated "CNA noted resident on floor sitting position back against corner/edge of recliner that she usually sits in. Is probable that resident attempted to transfer self from w/c to recliner. Clip alarm not in place in w/c. CNA missed putting the clip alarm in w/c. Was an unwitnessed fall. Did not hit head...Dr (name) here et [and] checked for injury. R [right] leg shorter than L [left] leg. Dr (sic) ordered for resident to have R hip xray..."</p> <p>The Nurses Notes, dated 6/17/11 at 1:00 P.M., indicated "Met with direct care staff concerning interventions placed 6/14/11 to use gait belt with all transfers and to attempt to assist res to bed between 7p-8p found to be effective."</p> <p>The MD Progress Notes, dated 6/28/11, indicated "Fall reviewed for 6/14/11. Incident occurred in process of transferring from chair to bed. Correction plan is to use gait belt with transfer, should have nonskid socks. Resident</p>						

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	<p>should be closely watched for fall probability. Staff counceled (sic)."</p> <p>The MD Progress Notes, dated 6/28/11, indicated "Fall reviewed for 6/17/11. Fall D/T [due to] dementia. Was attempting to transfer. Sensor not on to alert staff. Fall resulted in fx [fracture] of rt [right] hip. Patient transferred immediately after examination of Medical Director. Recommend staff be counseled (sic) this did occur."</p> <p>In an interview with the Administrator, on 7/14/11 at 11:00 A.M., no further information was provided.</p> <p>This federal tag relates to Complaint IN00092272.</p> <p>3.1-45(a)(2)</p>						

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